Infinite Care Limited

Care Connect

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

An announced inspection was undertaken on the 23rd of February and the 14th of March 2017.

Care Connect provides care and support to people living in their own homes in central Cheshire

Since our last visit in August 2016, the registered provider had employed a new manager. This person was in day to day control of the day to day management of the service and had yet to become registered with us. Our records confirmed that this person had commenced the registration process with us.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last visit in August 2016, we identified breaches in Regulations 17 and 18 of the Care Quality Commission (Registration) Regulations 2009. The breach of Regulation 17 related to the fact that staff did not receive sufficient training and supervision to perform their role. The breach of Regulation 18 related to the fact that the registered provider had failed to inform us of significant incidents that adversely affected people who used the service.

On this inspection we saw that improvements had been made. Staff had received training suitable for their role and supervision of staff was received by all staff on a more regular basis. This meant that people who used the service could be confident that they were being supported by well trained and accountable staff.

On this visit we were also able to confirm that improvements had been made by the agency in notifying us of significant events. This was confirmed through looking at our own records and records maintained by the agency.

People told us that they felt safe although this related to when they were supported by regular care staff. On occasions, they felt less secure when supported by unfamiliar staff. Three people also told us that calls were missed on occasions with no information given as to why this had been the case. The registered provider had a system for monitoring any missed calls and had not been alerted to these occasions. There was no evidence that these had had an adverse impact on people. Other people had concerns about the levels of hygiene used by some staff with reports of them not using personal protective equipment (known as PPE) such as gloves and disposable aprons while assisting with personal care. Staff had revived training in infection control, policies were available devised by the registered provider and staff told us that sufficient supplies of PPE were available to them.

Staff had a good understanding of the types of abuse that could occur and how this could be reported. Staff had received training in safeguarding and this was confirmed through training records. Staff were also aware

of how they could report concerns about the agency's practice to external agencies such as the Local Authority or CQC.

Risk assessments were in place for each person highlighting the risks they faced for their environment as well as risks in providing support to them and the considerations staff needed to make to keep people safe. All risk assessments we saw were up to date and had been reviewed.

People told us that they received their medication when they needed it. Care plans indicated that where people were independent with managing their own medication, this was encouraged. Staff had received medication training and had had their competency to assist with medication assessed. Medication administration records (known as MARS) were retained by the office for auditing purposes.

A computerised system was in place for matching staff with people who required support. This enabled a rota to be produced for each member of staff. Staff were required to log in when they arrived at a person's home and this was detected by the computer system.

Staff now received more consistent training. A training co-ordinator had been employed by the registered provider since our last visit. They gave us an account of how training needs had been identified through supervision, the new induction process that had been introduced and how training was updated. People who used the service had mixed views on how well trained staff were. Some felt that staff knew what they were doing whereas others commented that staff needed more training in infection control.

Staff had received training in the Mental Capacity Act 2015 and this was confirmed by staff and through training records. Staff were able to give an overview of how they assisted people to make choices relating to their support. Care plans included reference to the capacity of people to make decisions.

Staff had received training in food hygiene. The nutritional needs of people were outlined in care plans were applicable. People who used the service told us that staff were able to give them choices in what they ate while others said that staff needed more knowledge in preparing meals.

People considered staff to be generally caring yet indicated that it was their regular staff that provided a caring approach. They told us that when supported by unfamiliar staff they had felt rushed, or support had not been given to their satisfaction which sometimes made them feel unsafe. Staff gave us practical examples of how people's privacy and dignity would be promoted.

Assessment information was gained by the registered provider prior to people receiving support from the service. This included assessments from Local Authorities who funded care as well as assessments undertaken by the agency. Assessments included all the main support needs of people which were then translated into a care plan. Care plans included a person centred approach providing an indication for staff on how to best support each person. People we told us they were aware they had a care plan in place. In one case, a person had difficulty in receiving a copy of a care plan despite requests and found that it was missing information on a health need they had.

A complaints procedure was in place as well as a more robust recording system when complaints were received. These outlined the nature of the complaint and responses made to address concerns. People told us that they knew how to make a complaint whereas others told us that they had not experienced a satisfactory response to concerns.

Staff told us that the management team were supportive and approachable. Following our inspection in

August 2016, we asked the registered provider for an action plan as to how deficiencies in standards were to be addressed. We did not receive an action plan yet this visit noted that improvements had been made.

Three people told us that they were not always clear about who was managing the agency.

Audits were in place in respect of daily records and medication. These were extended to care plans and risk assessments. Our last visit had found that daily records were inconsistent yet this visit found that more robust action had been taken through team meetings and supervision to address any recording issues in daily notes.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

People told us that they felt safe when supported by their regular staff, however did not feel safe when supported by staff who would not normally attend their call.

People had concerns about hygiene practices adopted by some staff.

The recruitment process was more robust compared with our last visit.

Staff had a good understanding of the types of abuse, how abuse could be reported and how they could report concerns to external agencies.

The management of medicines promoted the wellbeing of people.

Is the service effective?

Good

The service was effective.
Improvements had been made in the training provided to staff and staff now received more regular supervision.
Staff had an understanding of the Mental Capacity Act and how people could be supported to make decisions.
The nutritional needs of people, where applicable, were included in care plans.

Is the service caring?

Requires Improvement

The service was not always caring.

People had mixed experiences about how whether they were supported in a caring manner. Some felt cared about while others felt rushed on occasions and felt that staff were more task orientated than person centred.

Staff gave us practical examples of how they would promote people's privacy and dignity.

Staff kept information relating to people they supported confidential.

Is the service responsive?

Good

The service was responsive.

People were aware of their care plans and had been involved in the assessment process.

Improvements had been made to the way the agency recorded and handled complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

The views of people who used the service were sought in 2016.

People did not always feel that the quality of the care provided was consistent. This showed that the registered provider needed to introduce more robust systems in relation to monitoring staff performance.

Improvements had been made in notifying CQC of significant incidents.

Audits were in place demonstrating that the quality of support provided by the service could be monitored.

Care Connect

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 23rd of February and 14th March 2017 and was announced on both dates. We gave the service 48 hours' notice so that the manager would be available to assist us with this inspection.

This inspection was carried out by an Adult Social Care Inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experienced assisted us by speaking with 7 people who used the service and 9 relatives by telephone to gain their experiences of using the service. In addition to this we received questionnaires from people who used the service. Comments from people are included within this report.

Before our visit, we reviewed all the information we had in relation to the service. This included notifications, comments, concerns and safeguarding information. Our visit involved looking at seven care plans and other records such as four staff recruitment files, training records, policies and procedures, medication systems and various audits relating to the quality of the service. We also observed care practice within the service.

We spoke with the Local Authority Commissioning Team. They have identified similar concerns to ones we had found in August 2016. A recent visit to the service by them had noted that there had been improvements within the provision of care by the agency.

Requires Improvement

Is the service safe?

Our findings

People had mixed experiences of the service. People told us that they felt safe with regular care staff but "felt anxious" with new staff as "they did not appear to know what they were doing". Others told us "The only problem is I can't always have the care workers who I trust and feel safe with". Other people had concerns about the levels of hygiene adopted by some staff. They told us "I have to prompt staff to wear gloves and to change them between tasks". Others told us that "they don't always wash their hands and don't always wear aprons which are important when dealing with personal care". People told us that they received their medication when they needed it.
People's experience of reliability of calls was also mixed. Three people told us "Calls are missed, we rang the office but still no-one came" and "Staff don't always attend on time, I am not informed if they are going to be late and get no explanation".

At our last inspection, we found that the recruitment process did not ensure that people who used the service were protected. We found that in one case, there was no photograph to confirm the identity of a member of staff. In addition to this, there was evidence of employment gaps on the person's application form with no evidence that this had been discussed with the person. This meant that the recruitment process did not consistently protect the people who used the service.

This visit found that recruitment files demonstrated that appropriate checks had been undertaken to determine the suitability of people to work at Care Connect. There was information to confirm the physical fitness of people for the role as well as application forms outlining their experience. Interview notes were also available. Disclosure and Barring checks had been obtained (known as DBS) to check if people had been convicted of offences which would affect their suitability to work there. Employment gaps were not present in any of the files we looked at and photographs were available to confirm the identity of staff.

References were in place although in two cases, we found that one person had only one reference and another had no references. This had been identified by the registered provider who had devised a plan of action to address this.

Two members of staff we spoke with had recently been recruited. Both found the recruitment process fair and had included checks necessary such as DBS to ensure that they were suitable people to support people who used the service.

Included in care plans was the support required by people to take their prescribed medication. Most people dealt with their own medication or relied on a family member to do this and this was recorded. Staff intervention was limited to prompting people to take their medicines rather than directly administering them. Staff told us that they had had medication training and this was confirmed through training records and certificates. A medication policy was in place outlining staff responsibilities in this regard. Medication administration records we saw had been completed appropriately. All medication records were subject to auditing by the management team and we saw evidence that this was undertaken.

Staff had a good understanding of the types of abuse that could occur. All staff told us that they had received safeguarding training and this was confirmed through records. Staff told us that they would report any concerns to the management team and were confident that action would be taken. The service had reported one safeguarding concern since our last visit. The service had taken appropriate action to deal with this.

Risk assessments were available for people. These reflected the potential risks that people in their daily lives. These risk assessments included those risks posed by their home environment as well as specific risks in the support they received on a daily basis. All risk assessments had been completed and updated where appropriate with the involvement of the people who used the service.

Risk assessments also included reference to infection risks within their own homes and through the provision of support. Staff told us that they had received infection control training and that this was confirmed through training records and certificates. Staff told us that the registered provider always provided them with enough personal protective equipment such as gloves and aprons (known as PPE) in order to deliver personal care hygienically. Care plans made reference to how infection control risks should be taken into account during the provision of support. While systems were in place to take infection control were in place, some people who used the service stated that staff did not always follow hygienic practice.

A record of accidents was available. The manager told us that there had been no accidents to record since out last visit. A process was in place for staff to report accidents experienced by people who used the service and that body map charts would be used in those instances to record any injuries. Given that there had been no accidents since our last visit, the manager had not been able to analyse any patterns or trends to prevent re-occurrence.

A computerised system was in place to help ensure that sufficient staff were in place to meet the needs of people. Details retained on the computer system included where staff were at any time, whether calls had been attended and rotas for the remainder of the week. When arriving at a person's home, staff were required to alert the management team of their arrival. The system enabled staffing levels to be maintained and monitored. Whilst three people stated that calls had been missed, the registered provider stated that they had not been aware of or alerted to any missed calls.

Good

Is the service effective?

Our findings

People's views on how effective the agency was in meeting their needs were mixed. People told us that when carers who supported them regularly, there were no problems with their support and that these staff knew what they were doing and supported them appropriately. When people had care staff they were not familiar with, people felt less assured "If I could have regular carers all of the time I'd be a lot happier", "I really don't like having carers who don't know me or how I like things to be done. My more regular carers know me well and I never worry when they are with me."

Outcomes for people in respect of nutrition were also mixed. People told us that they felt some staff lacked basic cooking skills while others told us "They will tell me what choices I have and then I'll decide what I fancy to eat.
Our last visit to the service in August 2016 identified that there had been a breach in regulation 17. This related to the governance of the service by the registered provider and focussed specifically on training and supervision for staff. We found that staff had received infrequent one to one supervision and that training needed to meet the needs of people who used the service had not always been undertaken. We also noted that the induction process for new starters had been limited.

Since our last visit, the registered provider had employed a training co-ordinator. We spoke to this person in order to gain an indication of their role within the service. As well as organising and conducting induction training for new staff, this person was responsible for ensuring that key training was up to date and identified when refresher training was needed. A training matrix was available identifying those staff who had completed key training and those that would need refresher training in the near future. This meant that training for staff had improved since our last visit to better meet the needs of people who used the service. Staff told us that they had received training key to their role. This had included training in health and safety topics as well as training linked to the needs of people such as specific health needs, medication or dealing with behaviours that challenged.

This visit found that staff had received supervision and that this had been recorded. Supervision enabled staff to discuss their general performance as well as being able to discuss any work related issues they had. Staff told us that they received supervision with their line manager. In addition to this, staff had their performance supervised through spot-checks done by the management team. The general performance of staff in providing caring and effective support was recorded.

A structured induction process was in place. This was linked to the Care certificate. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers. The induction also comprised of introducing new starters to the agency, providing key training such as health and safety and safeguarding and providing people with the opportunity to shadow existing members of staff on calls. Two new starters told us that they had had the opportunity to shadow existing staff for two weeks and then had their competency to work alone assessed. These staff told us that they considered the induction process had prepared them for their role in supporting people who used the service.

Staff we spoke with who had worked with the agency for longer told us that they had received an appraisal of their work. This was confirmed through records.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA

Staff were able to outline their knowledge of the Mental Capacity Act. They confirmed that they had received training in this. This was confirmed through training records. Care plans included a reference to the mental capacity of individuals. This included whether people had the capacity to agree to personal care and other forms of support. Care plans included how the consent of people was obtained. There was evidence that key documents, seeking the consent of people, had been signed to acknowledge their agreement to the support they received. Staff told us that as part of them visiting people, they always obtained verbal consent before assisting them.

Care plans also included reference to the communication skills of people. It was acknowledged that some people had limited communication and that staff needed to take steps to effectively communicate with them. This included speaking clearly or slowly to people as well as communicating with them at eye level.

Some people required support with eating and drinking as part of their care package. Included within care plans was an indication of whether support was required in food preparation. These included steps on how nutrition was to be maintained and any specific dietary requirements. Preferences in respect of food had been recorded. Training records suggested that staff had received food hygiene training. Daily records which accompanied care plans made reference to what meals had been prepared as well as a commentary about people's appetites. Where people were independent in preparing meals or relied on family members, this was outlined in care plans. People's views, however, provided an inconsistent view of their confidence in cooking and food preparation skills.

Requires Improvement

Is the service caring?

Our findings

People had mixed experiences of how caring the agency was. People told us "My regular carers listen to me and will always do things the way I like them to be done", I receive a wonderful service from Care Connect and have no complaints whatsoever", "One member of staff [name] usually did the tea and night call was brilliant and would do anything without asking". They told us "They always make sure that the curtains are closed and my bedroom door is closed before they begin to help me undress for bed", and "Some of the carers are good and will listen".

Others gave specific examples of where they considered the agency did not provide a consistently caring approach. One person told us that they felt rushed during their support. Another person's perception was that some care staff wished to get everything done "as quickly as possible" and that some staff support was task orientated.

Three people told us that there had been occasions when calls had been missed with the reasons for these not being provided to them. The registered provider told us that they had not been alerted to or were aware of any missed calls through the use of the their monitoring system. People felt that some staff appeared to be lacking in skills such as preparing food and basic hygiene. This meant that people received an inconsistently caring approach from the agency.

Care plans outlined how the privacy and dignity of people would be upheld. These included step by step guidance for staff on how support should be provided in personal care tasks taking privacy into account. Staff gave us examples of how they would promote people's privacy in personal care tasks through practical means of ensuring that doors were closed and curtains being closed. Staff told us that on arrival at people's homes they would introduce themselves, ask about someone's wellbeing and then ask them what support they needed on each occasion.

Staff had signed a confidentiality policy. This outlined a commitment from the registered provider to ensure that personal details or views of people were kept within the agency. Information contained with the agency's service user guide outlined this commitment.

The service user's guide contained an overview of what people who used the service could expect during their support. This made reference to maintaining the rights of people, promoting their dignity and maintaining their privacy. Other commitments within the service user's guide focussed on independence and their rights as individuals. The guide further outlines the process of when people are first supported by the agency. This included reference to the assessment and care planning process.

While no person received the involvement of advocacy services at the time of our visit, there was information included within the guide of a local advocacy agency and their contact details.

Good

Is the service responsive?

Our findings

We asked people who used the service and their relatives about care planning. People gave us mixed accounts of their experiences of how needs were met through the care plans used by the agency. They told us "I have a care plan in my folder" and "it has taken a long time to get a copy of the care plan and when we got it, it was missing important information". People's experiences were also mixed in relation to their level of involvement in care plans. Some people told us they were involved in their care plans while others considered it was "something that the agency does".

People told us that they knew how to make a complaint. They said "I could telephone the manager" or "I could get someone to speak with them". Another said "we have not needed to make any complaints". Three people told us that they did not feel that the agency had responded well to complaints.

Assessment information was in place for care plans we looked at. This included information from local authorities who funded support or assessments from the agency's own assessment form. All assessments included reference to the main physical and social needs of people, the ways in which they needed support and their capacity to make decisions. Assessment documents then were translated into a care plan. Assessments included the views of people who used the service and any information about themselves which could assist the staff to provide a good standard of support.

Care plans we looked at included a support plan which was personal to the needs of each person. These included a step by step guide as to how people should be supported and included a reference to the needs and wishes of people. Care plans showed evidence of review with the agreement of people who received the support. As support needs changed, there was evidence that care plans had been adjusted to take these needs into account through increased visits to that person. Care plans were backed up by daily records. These provided a commentary on the progress made by each person and the support they had been provided with on each visit. These daily records were then returned to the office so that check on their accuracy could be made. Care plans we looked at had been signed by people to confirm their agreement with the support to be provided.

While the agency provided personal care in people's own homes, there was an appreciation of daily activities that people pursued. Care plans included what activities such as day services that people attended and the times that staff should attend people's homes in order to ensure that people were ready to access these services in good time.

Our last visit noted that there had been deficiencies in the way the registered provider had handled complaints. This had included an out of date complaints procedure, incorrect information on how to contact the Care Quality Commission and a lack of detail on what action had been taken to address complaints. This inspection found that there was a more robust complaints procedure and that records outlining complaints that had been made were clearer with how complaints had been responded to. In all cases, complaints or concerns had been responded to in a timely manner. The service had received three complaints since we last visited. Two evidenced that action taken with one only having just been received by

the service.

Requires Improvement

Is the service well-led?

Our findings

People told us about the running and management of the agency. People we spoke with were clear about how to contact the office if they needed to but some were unsure who the manager was. They said "I don't really know who is in charge", "I could not tell you who runs the agency, I have not seen anyone since I started with them" and "I think the manager came to see me once but I could not tell you who they were". We asked people about whether their views on the service had been gained through quality assurance questionnaires. They told us "I have never been asked for my opinion before now other than the questionnaire you have sent me". The registered provider sent us, subsequent to the inspection, details of the last quality assurance questionnaire done in 2016.

Our last visit had identified breaches of our regulations. We had asked the registered provider to send us an action plan on how these issues were to be addressed. The registered provider did not send an action plan to us when we asked. However, this inspection did find that improvements in the identified areas had been made.

At our last inspection, we identified that there had been a breach in Regulation 18 relating to notifying us of significant events that had involved the service. This meant that people who used the service were not receiving care from a well-managed agency. There had been two safeguarding allegations that had not been reported to us. On this visit, we checked our records and noted that adverse incidents that affected the wellbeing of people were now reported to us. We were able to cross reference this notification with records held by the service in respect of this incident with confirmation that it had been sent to the Care Quality Commission.

Our last visit also noted that policies and procedures were not updated. This had been now been addressed.

People told us without exception that the agency had not sought their views on the quality of support they received. This inspection found that questionnaires had been sent to people in 2016 with results provided to us subsequent to the inspection.

Since our last visit, the registered provider had employed a new manager. This person was yet to be registered with us yet this process to become registered had started as confirmed through our records.

Comments we received from people who used the service during this inspection highlighted inconsistencies in outcomes for them. They told us that they felt safe with well trained and caring regular staff yet this was different when care staff who were unfamiliar to them came to support them. They stated that they did not feel confident with them and considered them to focus on tasks rather than the person, in need of more training and lacking in basic hygiene awareness.

We looked at how the management team audited the quality of support provided by the service. Daily records were returned to the office and were checked to see if information that was required had been recorded by care staff. Where issues arose from audits, there was evidence that this had been raised in

supervision sessions with staff, raised in team meetings or that information reminding staff to ensure a good standard of record keeping had been addressed. This was an improvement on our last visit which had seen inconsistent auditing of these records.

Further audits were available in respect of medication records. When completed, these were returned to the office for checking to ensure that they had been completed appropriately. Audits on the quality of support were completed through spot-checks undertaken by members of the management team to assess individual care staff. These had not been done at our last visit. The outcome of these was recorded and staff told us that spot-checks were carried out. The spot-checks related to practical issues such as the wearing of gloves and aprons to the way the privacy of people had been promoted.

Confidential records maintained by the agency were securely locked when not in use or when the office closed. All care plan records we looked at were up to date and showed evidence of review. This was also the case for risk assessments.